



DENTAL BOARD OF CALIFORNIA
 1432 HOWE AVENUE, SUITE 85, SACRAMENTO, CA 95825-3241
 TELEPHONE: (916) 263-2300
 FAX: (916) 263-2140



APPLICATION FOR ADULT ORAL CONSCIOUS SEDATION CERTIFICATE

Sections 1647.18-1647.26 Business and Professions Code;

Non Refundable **FEE: \$200**

(must be enclosed with application)

Section 1021 Title 16 California Code of Regulations

Receipt No. _____ RC _____

Amount _____ Initials _____

Certificate No. _____

Issued _____

Name _____

Address of Record (Mail)

Street and Number _____

City _____ ZIP Code _____

Address of Practice if different

Street and Number _____

City _____ ZIP Code _____

Telephone number () _____ FAX _____

Email address _____

Birthdate _____ Dental License Number _____

QUALIFICATION – Indicate under which method listed below you qualify for an oral conscious sedation certificate for adults and attach appropriate documentation.

☐ Successful completion of a postgraduate program in oral and maxillofacial surgery approved by the Commission on Dental Accreditation or a comparable organization approved by the Board.

☐ Successful completion of a periodontics or general practice residency or other advanced education in a general dentistry program approved by the Board.

☐ Successful completion of a Board-approved educational program on oral medications and sedation. Applicant must provide completed Form OCS-2 to document completion.

☐ Documentation of 10 successful cases 1647.20(d). Attach Form OCS-4 with copy of treatment records.

Pursuant to Business and Professions Code 1647.22(b), a dentist who administers, or who orders the administration of oral conscious sedation for an adult patient shall be physically present in the treatment facility while the patient is sedated and shall be present until discharge of the patient from the facility.

Provide the addresses of all locations of practice where you order or administer oral conscious sedation to adult patients.

IF NECESSARY, CONTINUE ON BACK OF THIS PAGE.

Certification - I certify under the penalty of perjury under the laws of the State of California that the foregoing is true and correct and I hereby request a certificate to administer or order the administration of adult oral conscious sedation in my office setting(s) as specified by the Dental Practice Act. I understand that falsification or misrepresentation of any item or response on this application or any attachment is grounds for denying my application for a certificate.

Signature of Applicant

INFORMATION COLLECTION AND ACCESS

The information requested herein is mandatory and is maintained by Dental Board of California, 1432 Howe Ave, Suite 85, Sacramento, CA 95825, Executive Officer, in accordance with Business & Professions Code, §1600 et seq. Failure to provide all or any part of the requested information will result in the rejection of the application as incomplete. Each individual has the right to review the personal information maintained by the agency unless the records are exempt from disclosure. Applicants are advised that the names(s) and address(es) submitted will be release to the public upon request and may be posted on the Internet.